

Referral to Medicaid Case Management



Patient name:			Humana ID:		Pharmacy:	
Patient address:						
Phone:		DOB:	Plan:	Effective date:	Type of referral: Routine Urgent	
POA:		Relationship:		Home phone:		Cell phone:
Family member name(s):		Relationship:		Home phone:		Cell phone:
Person making the referral:				Phone:		
Patient's PCP:		PCP address/office phone/fax:			PCP email:	
Referring patient to:		Case management ____ Disease management ____ Moms First: ____				
Demographics (include level of function, living arrangements, transportation, challenges for patient, etc.):						
Problem list:						
Hospitalizations (include date and name of hospital):						
Procedures/surgeries:						
HEDIS® measures:						
Medications:						
Other:						

Please fax completed form to 1-833-939-1312 or send via email to:

KYMCDCaseManagement@humana.com

Toll-free case and disease management telephone: 1-888-285-1121

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